Vol. 18 No. 3 Fall 2002

MINNESOTA
Board of Dentistry Updates

"To ensure that Minnesota citizens receive quality dental health care from competent dental health care professionals"

In this issue…

Message from the President 2

Rulemaking Status Report 2

Need for Interpreters in Dental Care, Part I 3

Discussion: Specialty Licensure 4

New Board Member 4

Displaying Licenses and Certificates 5

Open Letter to New MN Legislature 5

Board and Committee Meeting Dates 5

You Have A Public File 6

Cultural Sensitivity: Its A Good Thing 6

Disciplinary Action 6

Renewal Time is Here 7

INFORMED CONSENT

Many complaints come to the Board from patients who claim that they never agreed to the treatment that was provided for them by their dentist. The issue of informed consent is an essential element of providing care.

Minnesota Rule 3100.9600, subp. 9, is the section of the Practice Act on recordkeeping that describes the components of informed consent. This concept is within the recordkeeping rule because of the importance of documenting that the information was shared with the patient, and that the patient made an informed decision. The minimum components of informed consent outlined in the rule include…

- **treatment options** have been discussed
- **prognosis, benefits, and risks** of **each** option have been discussed, and
- **documentation that the patient has consented** to the chosen treatment.

Kelly Edwards (Ethics in Medicine, University of Washington School of Medicine, 1999: eduserve.hscer.washington.edu/bioethics/topics/consent.html), notes that the informed consent process originates from the legal and ethical right of the patient to "direct what happens to his/her body and from the ethical duty of the [heath care provider] to involve the patient." She goes on to describe more fully the elements of informed consent, adding that there should be discussion about the nature of the procedure, reasonable alternatives, the relevant risks, benefits, and uncertainties related to each alternative, an assessment of patient understanding (including whether the patient is competent to make the decision at hand), and the acceptance of a particular intervention by the patient. Others have suggested that a comprehensive informed consent would include discussion of the risks and benefits of doing nothing, and also include disclosure of the costs of the various options.

In health care, the marketplace is skewed in the provider's favor– as the dentist, hygienist, and dental assistant have significantly more knowledge about dental issues than the average patient. Patients rely on their provider's knowledge, and trust that their dental provider will make them aware of options available. In this way, the patient can make a reasonable decision about their own health care.

Surprisingly, the American Dental Association's *Principles of Ethics and Code of Professional Conduct* is silent on the issue of informed consent. The American Medical Association, however, addresses informed consent concerns in great detail. The AMA's *Code of Medical Ethics* (chapter 8.08) states that a "patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." The provider has the ethical obligation "to help the patient make choices from among the therapeutic alternatives consistent with good… practice."

Case study: A patient presents with caries on an anterior tooth. You are aware that the patient's insurance will cover an amalgam restoration, but will probably not approve a composite restoration. You believe that, aesthetically, the composite is the best option. What do you tell the patient?

> [You inform the patient of your diagnosis, and your preferred course of treatment. You also inform the patient of other options, and of the additional cost that the patient may be responsible for depending upon the treatment selected. Allow the patient to decide which option they prefer. And, you write it all down].

Cont. on Page 7

MESSAGE FROM THE PRESIDENT

Freeman Rosenblum D.D.S., M.S.D.

The Minnesota Board of Dentistry is very concerned about our ability to meet the needs of the various dental professionals and the general public. At any one time, we are addressing complaints that may have an adverse affect on a dentist, hygienist or registered dental assistant. At other times the complaint and credential committees may be trying to educate the individual to improve practice without any negative future implications. This agency also has the duty of evaluating and accepting new licensees into our state. In most cases, this is a positive experience.

In addition, it is our duty as a government agency to protect the public. In a given year the dental board receives hundreds of complaints from the citizens of Minnesota. The relationship we establish with that person can by very intense. On the one hand, it is imperative that they recognize that everything will be reviewed thoroughly before any decision is made. At the same time, many of the cases are closed without any formal action taken against the licensee. Those individuals may continue to contact our board after the fact to express their displeasure with our decision. In some cases they may lose interest in pursuing the complaint process because they changed their mind or were upset with the time that it has taken to resolve their concerns. After a complaint is resolved to the satisfaction of the complainant, we may receive a very positive response via phone or letter.

Thus, dental staff and board members are faced with both positive and negative experiences by the dental licensees, registrants and the public. The focus of the Board in resolving complaints is more broadly related to the effect of the allegations on public safety than it is on the individual compliant. It is very important that we handle these issues in an appropriate and professional fashion. At the same time, we must abide by the statutes and rules of the dental practice act.

During this next year the dental board plans on conducting a survey to members of the various dental professions. We want to know how we are doing. Following that project, the public will also be contacted. The exact structure of these questionnaires has not been formalized. It would be very appreciated if those contacted would respond in a timely fashion. The more information that is gathered, the better it will assist us in addressing all of the above issues.

RULEMAKING STATUS REPORT

The Board recently published a notice of intent to adopt rules without a hearing. The guidelines of the process allow for the public to request a hearing and, if 25 or more qualified requests are received, then a hearing is to be scheduled.

The proposed rules – which address expansion of procedures which hygienists and assistants are able to provide under various levels of supervision – have drawn the prerequisite number of hearing requests. The sole issue of contention relates to an attempt to clarify rule language on the application of topical medications. With the proposed change to rules, the Board desires to make it clear that the intent of the rule is to allow the application of medications only within the oral cavity. As a result of the hearing requests, the Board will revisit the proposal.

A second set of rule changes is being proposed that addresses allowing certain restorative functions to be performed by a registered dental assistant or dental hygienist. Following many public discussions at Policy Committee, Allied Personnel (Auxiliary) Education Committee, Executive Committee, and Board meetings, a proposal was developed to allow allied personnel who have received additional, approved training to place amalgam and glass ionomer restorations. The official language of this proposal will be published on the Board's web site and in the State Register in late December.

IMPORTANT: None of these proposed rules have been adopted to date. The duties and levels of supervision are still in the discussion stage. Public notice will be given on developments in these proposals. If you wish to be included on our e-mail or mail notification list, please contact the Board directly.

NEED FOR INTERPRETERS IN DENTAL CARE: Part I

The basic concepts of informed consent require that the patient understands what is going on, and that it is the obligation of the dental professional to ensure that the understanding is made. The list of possible communication barriers is long, and includes special attention to treating (a) patients who are illiterate, (b) patients who do not speak or understand English, or (c) patients who are hearing impaired.

Illiteracy

In the United States, approximately 1 in 5 people are considered functionally illiterate. Because of the stigma attached to illiteracy, this population finds numerous coping mechanisms to hide their inability to read. These individuals are often able to deceive others with whom they interact. Consider, for example, that perhaps 22% of your patients are not able to understand the health history forms or the 'informed consent' documents that they are asked to sign. Rather than assume that a patient has understood the paperwork, it would be worthwhile to walk through the forms with your patient to ensure that the information is clear. It is much better to be certain of potential concerns before treatment to *prevent* the occurrence of an avoidable adverse incident.

Language Differences

Working with non-English speaking patients, or those with limited English proficiency, poses similar concerns. The federal government's Office for Civil Rights reports that the United States is home to millions of individuals who cannot speak, read, write, or understand the English language at a level the permits them to interact effectively with health care providers. Because of these language differences, these individuals are often excluded from programs, experience delays or denials of services, or receive care based on inaccurate or incomplete information. Simply because a patient has successfully found their way to your office and has been seated in your dental chair does *not* imply that they (a) understand what it is you are doing or (b) have agreed to proceed with treatment. The use of qualified interpreters is essential for ensuring appropriate communication.

What makes for a qualified interpreter? Trained interpreters have experience communicating not only the language, but also providing cultural context for the patient and provider. An interpreter will assist with making the communication clear. Although interpreters are not currently regulated, they should be familiar with a code of ethics. The ethical code for interpreters requires confidentiality, accuracy, complete and nonjudgmental interpreting of everything said by the provider and the patient, and conveying cultural context.

As reported on the DiversityRx website, things that can go wrong with an unqualified interpreter could easily include:

- Failure to clarify misunderstood information
- Misinterpreting particular words and idioms, or otherwise distorting the message by adding information, omitting information, or changing the meaning
- Responding in place of the patient without interpreting
- Failing to interpret a response from the patient
- Volunteering information or interpreter's opinions concerning the patient

Any of these communication errors by an untrained interpreter could lead to misdiagnosis, inappropriate treatment, and liability for the provider.

How about using a family member to interpret? Using a family member can be awkward and inappropriate because of confidentiality and cultural issues. A patient may not be totally honest or comprehensive in discussing health history or concerns (i.e., use of oral contraceptives, HIV status, mental health issues) when the interpreter available is a relative or close friend. Additionally, generational and cultural issues arise when a child or younger relative is relied upon for interpreting services. It is not uncommon for a younger family member to selectively edit the discussion between the health professional and the patient, resulting in bad information being transmitted both ways. An objective, third-party interpreter will be much more reliable.

Hearing Impaired Patients

Hearing-impaired individuals are afforded additional rights to services under federal law. The Americans with Disabilities Act mandates that reasonable accommodations be made to provide health services to hearing impaired patients. According to the Department of Human Services Provider Manual, "all providers are required to provide sign language interpreter services when such services are necessary to enable hearing impaired recipients to obtain covered services." Standards of Practice (sop.com) suggests that we must go to great lengths to empathize with deaf and hard-of-hearing patients to develop and maintain lines of communication and mutual respect. Utilizing a professional sign language interpreter is one of the options available to ensure satisfactory communication.

Note: Part II of this series will address questions regarding how to arrange for an interpreter, who pays for the service, viable alternatives, and documentation recommendations. Part II will be published in the next issue of *Updates*.

DISCUSSION: SPECIALTY LICENSURE

At the present time, the Minnesota Board of Dentistry can grant specialty license in all of the dental specialties recognized by the American Dental Association (Minnesota Statute 150A.06, subd.1c). As stated in the law, only oral surgeons can be issued a specialty license without first obtaining a general dental license. All other specialties are obligated to have an equivalent license from another state before applying for a specialty license. The present statute (subd. 3), however, allows that all or any part of the examination for dentists – except that pertaining to the law of Minnesota relating to dentistry and the rules of the Board – may be waived at the discretion of the Board for an applicant who presents a certificate of qualification from the National Board of Dental Examiners, or evidence of having maintained an adequate scholastic standing as determined by the Board.

The Board has had discussions with representatives of the Minnesota Dental Association and most of the state's specialty groups regarding the subject of specialty licensure and the waiving of the clinical examination. In addition, we recently received supportive recommendations from the ADA House of Delegates and the American Association of Dental Examiners (AADE) for consideration.

The Board of Dentistry clearly understands that its primary objective is to protect the public. We must, however, not lose sight of the fact that there is a projected shortage of well qualified generalists and specialists to care for the needs of our citizens. We also recognize that the University of Minnesota has numerous openings for qualified educators. The competition is very keen across the country to fill these positions. Frequently, the subject of supplemental income is discussed during the interviews. At present, faculty dentists (generalists or specialists), cannot practice except when engaged directly in research or education unless they hold a general dental license (subd.1a). Should we make it easier for the dental school to recruit by eliminating or revising faculty licensure by waiving the clinical examination in certain cases? This concept would then allow the dental school to be more competitive in recruitment. In addition, the dental workforce would be increased to deal with access issues.

Finally, should the provisions of this statute relating to specialty licensure be changed, treating all of the recognized specialty groups equally? The credentialing process could also be refined for these individuals. The AADE and ADA have made recommendations on this issue which include the following:

- All specialists should be required to have passed a state dental board general dental examination and have a general dental license before being eligible to be credentialed or being granted a specialty license.
- Specialists who have passed a specialty examination in another state should be granted licensure by credentials without further clinical examination.
- Dental specialists who hold diplomate status from an ADA-recognized specialty certifying board, or who have completed an advanced program accredited by the Commission on Dental Accreditation, and meet all other state requirements for licensure should not be required to take any additional general dentistry examinations.

The Policy Committee and the full Board have been discussing this subject for the last nine months. A proposal will be brought to the full Board for approval at the December public meeting. If supported, the resolution will then be brought to the legislature to seek a change in statute.

NEW BOARD MEMBER

Effective August 1, 2002, Governor Ventura appointed Gerald McCoy of Eden Prairie, Minnesota, to serve as a public member on the Minnesota Board of Dentistry. Currently, Mr. McCoy is director of educational planning for Cuningham Group, a Minneapolis architecture firm that builds many schools. He was the school superintendent for Eden Prairie Schools for 16 years before retiring. Mr. McCoy is also very involved in his community and serves on several boards, including Minnesota Council for Quality. This year, Mr. McCoy ran for Mayor of Eden Prairie. McCoy replaces Julia Huebner to complete a four-year term that expires on January 6, 2003.

DISPLAYING LICENSES AND CERTIFICATES

It is stated in Minnesota Statute 150A.06, Subd. 6, that at every clinic where a licensed or registered dental professional practices, the professional must display an original license certificate and annual renewal certificate. *These documents cannot be photocopies.* If a dental professional practices at multiple practices, they must display these documents at all locations.

You may order duplicate licenses and annual renewal certificates by contacting the Board office at any time or you may order them on your annual license/registration renewal application. The additional cost is $20.00 for a duplicate license for dentists and hygienists and $10.00 for a duplicate certification for dentists, dental hygienists or registered dental assistants.

MINNESOTA BOARD OF DENTISTRY
University Park Plaza, 2829 University Avenue SE, Suite 450
Minneapolis, MN 55414-3249 www.dentalboard.state.mn.us
Phone 612.617.2250 Fax 612.617.2260
MN Relay Service for Hearing Impaired 800.627.3529

November, 2002

An Open Letter to the New Minnesota Legislature

Dear Senators & Representatives:

Congratulations on your election to state office, and your commitment to public service.

The Minnesota Board of Dentistry is one of 16 health-related Boards established under statute to regulate various health professions. Our purpose is to protect the public by establishing licensing standards (including initial licensure and continued competence), and by managing complaints and compliance.

The Board generates its own income through licensing fees, and does not rely on the state's General Fund.

The Board works well and closely with the professional associations (Minnesota Dental Association, Minnesota Dental Hygienists Association, Minnesota Dental Assistants Association, and the educators' associations). *The important distinction, however, is that the Board act solely to protect the public, whereas the associations primarily represent the interests of their respective professions*. Please keep this in mind when considering policy decisions.

Access to dental care is among the significant issues facing Minnesotans. We as a Board weigh this, public safety, and other concerns very heavily when formulating regulations affecting the practice of dentistry. The Board acts as a center for promoting public discussion about dental care, and can provide a tremendous, objective resource. It is my hope that we will have the opportunity to work together, and that the Board members and staff can be a resource to you.

Please feel free to contact us at any time. We look forward to working with you in the coming session.

Sincerely,

Marshall Shragg, MPH
Executive Director

UPCOMING BOARD AND COMMITTEE MEETINGS

Complaint Committee "B"	December 12, 2002, 8:00 a.m.	CLOSED
Board Meeting	**December 13, 2002, 8:30 a.m.**	**OPEN**
Complaint Committee "A"	December 20, 2002, 8:30 a.m.	CLOSED
Complaint Committee "A"	January 17, 2003, 8:30 a.m.	CLOSED
Complaint Committee "B"	January 23, 2003, 8:00 a.m.	CLOSED
Board Meeting	**January 24, 2003, 8:30 a.m.**	**OPEN**

NOTE: The Board offices will be closed on Thursday, November 28 and Friday, November 29 for Thanksgiving, Wednesday, December 25 for Christmas, Wednesday, January 1 for New Years Day, and Monday, January 20 for Martin Luther King Day.

YOU HAVE A PUBLIC FILE

Statistical data on licensed and registered dental professionals are public information. This information is useful to patients when seeking a health care provider. The Board can offer information on when they were licensed or registered, their age, the school they graduated from, the address and phone number they have listed with the Board and if there is any disciplinary or corrective action on their license or registration. Minnesota Statute 150A.09 Subd. 3 states;

> *Every dentist, dental hygienist, and registered dental assistant shall maintain with the board a correct and current mailing address. For dentists engaged in the practice of dentistry, the address shall be that of the location of the primary dental practice.*

The Board can only list one address and phone number for each dental professional. Although the above mentioned Statute indicates that for licensed dentists it must be their practice, we have always left it up to dental hygienists and registered dental assistants to indicate whether they would prefer their home or practice address/phone number to be listed with the Board. Again, we remind you this information can be given out to the public upon request.

If you need to change the address and phone number the Board has listed for you, the Board must receive this information in writing with a signature. (See last page of newsletter.) When moving to a new location, you must inform the Board within 30 days of changing the address.

It is important to keep your address and phone number current, as this is the only way the Board can inform you of any issues that affect your license or registration.

CULTURAL SENSITIVITY:
IT'S A GOOD THING

The concept of cultural sensitivity is too big for a short article to begin to address. As it would be impossible to be comprehensive in the context of the newsletter, please consider this as a suggestion to seek out additional opportunities for more in-depth attention to this concern. Concerns about cultural sensitivity have been raised in the course of reviewing a number of complaint cases recently. In these cases, the provider's professionalism was questioned as a result of apparent bias based on differences related to financial status, national origin, race, English proficiency, gender, and other factors.

Title VI of the Civil Rights Act of 1964 provides the foundation for much of the development of awareness to multicultural issues. Title VI prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. Awareness of differences and discrimination can lead to cultural sensitivity. The outgrowth of cultural sensitivity is cultural competence, which depends on "institutional ethos, or the specific attitudes and practices of individual practitioners." (Diversity Rx: www.diversityrx.org/BEST/1_1.htm.) The key is that awareness, sensitivity, and competence are individual responsibilities that become institutionalized.

The State's Office of Diversity and Equal Opportunity (ODEO) has established overall goals for state agencies that provide a basis for other workplaces. The overall goal of cultivating respect for individual differences includes practices such as:

- Creating workplaces that welcome, respect and value people of all abilities, cultures, races, genders and ethnic backgrounds.
- Ensuring that diversity is reflected in all activities, including planning, purchasing, decision-making and design and delivery of services to customers.
- Identifying and removing barriers to make programs and services accessible to all Minnesotans.
- Developing partnerships with public and private organizations to share techniques for enhancing diversity.

Additional efforts at understanding and improving channels of communication are good for the profession, good for the patient, and good for business.

DISCIPLINARY ACTIONS

Harold G. Swennes, D.D.S.
Order for Limited Conditional,
Chisholm, MN
09/20/02

Note: the full text of orders enacted since September 9, 2002, may now be viewed on the Board's Web site. Go to www.dentalboard.state.mn.us, click on 'Disciplinary Actions,' and click on the 'highlighted' order that you are interested in reviewing.

The Board will be renewing additional cases at its December 13, 2002 meeting. The Web site will be updated the following week.

Definition of Terms:
Conditional License – licensee may continue to practice but must meet specific conditions of Order.
Limited License – licensee may continue to practice buy may not perform certain procedures specified in the Order.
Suspended License – licensee may not practice for a specified length of time or until certain conditions are met.
Unconditional license/registration – all terms of the Order have been met, the individual's license/registration is fully restored, and s/he may practice without special conditions or restrictions.

RENEWAL TIME IS HERE!

How To Avoid Those Common Pitfalls

It's time to renew your license/registration and **ALL** Minnesota dental licensees and registrants must renew every year – even if you just received your license. Renewal applications will be mailed out the first week of November. If you haven't received your application by the end of November, call the Board for another one or download a copy off the Board's website (www.dentalboard.state.mn.us/main-forms).

There are common pitfalls that are shared by persons in each profession. Recognizing these common errors may assist you in avoiding them and ensure trouble-free renewals. Here's what to be aware of:

Sign your renewal application

All applications must be signed by the licensee/registrant.

Keep your address current

Law requires that a licensee/registrant must notify the Board within 30 days of an address change.

Mail the appropriate fee with your renewal application

Applications must be returned unprocessed if the fee is incorrect (whether it is more or less than what is actually due), or if the fee was mailed separately.

Sign your check

Checks must be signed or they cannot be processed.

If mailing several applications with one check - double check all applications and re-add the total.

If one application isn't signed or the amount of the check is wrong, all the applications will be returned. And, if not corrected and returned by December 31, 2002, a late fee will be charged on all applications.

All applications must be received or legibly postmarked on or before December 31, 2002. If not, a late fee is charged (1/2 the cost of your renewal fee). Renewal certificates will be mailed out the first 2 weeks in January.

Informed Consent *(Cont. from Page 1)*

Case study: A new patient appears at your office for a scheduled appointment. Upon greeting the patient, it is clear that the patient does not speak or understand English, but is in a great deal of pain. How would you approach this case?

[The patient is not capable of providing informed consent, as they do not understand what is wrong or what their options, obligations, or risks are. Although the patient is in pain, it is not a true emergency situation that would allow you to act. You are not able to proceed with treatment unless you are able to utilize an interpreter. Therefore, an interpreter should be arranged or the patient should be referred to a clinic where those resources are available. And, you write it all down].

Case study: Your patient's parents drop off their 14 year old child at your office on their way to do some errands. The child has recently had his braces removed by the orthodontist, and needs a prophy and some restorative work done. What do you do?

[The patient's parents must give consent for their minor child's care. Although it would be best to have them present and sign a consent for treatment, you may contact them by phone and present the options. Once consent has been given by the parent(s), you should explain to the child what will be done, and proceed with treatment. Again, you write it all down].

Case study: You have completed an exam on a patient, and have told the patient that they would need a significant amount of treatment. You ask the patient to "open wide," and begin your work. The patient is later surprised by the work that was done, and the cost of treatment. What went wrong?

[Implied consent is not acceptable, as too many assumptions are made. This situation requires a full discussion of options and a treatment plan accepted by the patient prior to proceeding. And, of course, you write it all down].

The AMA (Office of the General Counsel, Division of Health Law, September 1998) tells us that "informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and a [provider] that results in the patient's authorization or agreement to undergo a specific… intervention." This is not a situation where a blanket authorization for "whatever treatment the dentist deems necessary" is acceptable; rather, invasive treatments require full disclosure and a non-coerced agreement that allows the patient to be involved in determining their care.

And, you write it all down.

If you have a name or address change you must inform the Board in writing within 30 days of the change. Practicing dentists are required to have their primary practice address on record with the Board. All others may list a home address. Note: Your name and address are public information. Request for e-mail addresses: The Board would like to occasionally send information affecting licensure to dentists, hygienists and assistants via e-mail alerts. Please provide the Board with your e-mail address if you wish to receive these notices.

NAME AND/OR ADDRESS CHANGE

Name (last, first, middle)	Former Name (if applicable)
Old Address Street: _____ City/Town: _____ State: _____ Zip Code: _____	**New Address(if applicable)** Street: _____ City/Town: _____ State: _____ Zip Code: _____
MN Dental License/Registration Number:	Daytime Phone Number:
Signature (Required):	Email Address:
	Effective Date:

✂ Please cut along dotted line and mail to Board office. ✂

MINNESOTA Board of Dentistry - Updates

2829 University Ave SE
Suite 450
Minneapolis, MN 55414

First Class
U.S. Postage
PAID
Permit No. 171
St. Paul, MN